# 

Save Face  
Luxira Aesthetics

Hyalase Consent Form

Patient Name:

Date of Birth:

**Consent for Treatment with Hyalase™ to Dissolve Hyaluronic Acid (HA) Dermal Fillers (Elective or Emergency Use)**

Hyalase™ is an enzyme which breaks down hyaluronic acid. Hyaluronic acid is the component of dermal fillers, but is also naturally occurring in the skin and soft tissues.

Hyalase™ (hyaluronidase 1500 units) is licensed and commonly used to boost absorption or dispersal of drugs injected into the skin and has an off license use in aesthetic medicine.

Occasionally dermal fillers need to be dissolved when the treatment outcome is unacceptable, when an adverse reaction to the implant has occurred, or there is a possibility of vascular occlusion and/or impending necrosis (tissue death) which could lead to the compromise of healthy tissue.

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| **Motivations and Expectations** |

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| **Alternative Treatments I have been Advised I may Consider;**  **Acceptance of present condition**  **Or**  **Massaging the area or leaving the dermal filler to break down naturally which may take several months dependent on the type of filler used and the area treated.** |

**Common Side Effects Associated with the Injection**

* Pain or stinging sensation when the injection is performed.
* Localised swelling, which may be marked in the first 24-72 hours.
* Redness and or tenderness
* Bleeding at the sites of injection
* Bruising. Rarely, bruising may be severe and may persist for several weeks.
* Numbness or itching of the area following injection.
* Loss of volume beyond the loss of correction the filler provided.
* Skin laxity which is expected to be temporary, but may be disfiguring until your own hyaluronic acid is replenished.

The results are unpredictable and more than one treatment 1-4 weeks apart may be necessary to achieve the desired result. Common side effects are expected to resolve spontaneously, within the first few days of treatment. Whilst not expected, it is possible that reactions described may persist for longer than expected and may inhibit your confidence to attend work or social events. You are advised to schedule treatment with this in mind, allowing time for common reactions such as bruising and swelling, to settle.

**Uncommon Side Effects**

* Infection
* Inflammation
* **Allergic Reaction**- a small percentage of the population may be severely allergic to Hyaluronidase, particularly those who are allergic to bee stings. **Hyalase™ administration can result in anaphylaxis a severe allergic reaction which in itself is life threatening and requires immediate medical attention and hospitalization.**

I understand that though complications are uncommon, they do sometimes occur. It is possible that side effects not described may occur and indeed that a complication not previously reported may occur for the first time.

I understand if I suffer any adverse reactions that are not expected, or concern me, I must contact the clinic. An appointment will be made for me to be seen. The clinic cannot take responsibility for complications or results that have not been reported, assessed, documented and managed in a timely fashion.

I confirm that the medical health history form has been completed truthfully and I am fully aware that withholding medical information, including history of previous treatment, may be detrimental to the safe and optimal outcome of any treatment administered. If there are any changes in my medical history, I must inform the practitioner.

Iconfirm that I have been provided with verbal and written information about this treatment which includes aftercare and follow up advice. I agree to follow the aftercare advice and understand this reduces risk of adverse reactions and helps ensure optimum results.

I understand information about me will be treated as confidential and access to it restricted in accordance with the Data Protection Act, unless specific permissions given.

**Permissions Requested;**

* I consent to my medical records being shared with appropriate professional staff
* On occasion it is helpful to share visual images of our own treatment results.

I consent to photographs being published for;

* Educational and training purposes with medical professionals
* Educational purposes with selected patients during consultation
* Educational/promotional purposes in the clinics portfolio viewed by selected members of the public
* Educational/promotional purposes on the clinic website
* Educational purposes for selected public events
* I understand that no fee is payable to me or any other person in respect of the material either now or at any time in the future.
* I confirm that the purpose for which the material would be used has been explained to me in terms which I understand and I may withdraw my consent to publish images of myself or share information at any time, by advising the clinic in writing.
* I understand I may receive a test patch in my forearm to establish whether or not I am allergic to
* hyaluronidase and will be required to wait in the clinic for (X minutes) to ensure no sensitivity has been observed before proceeding with treatment. If allergy is confirmed, and treatment cannot be performed I understand payment of £………………. will be charged for the patch test alone.
* I acknowledge that I will have to remain at the clinic for (X minutes) after the procedure so that I can be observed by the medical staff and that I will need to return to the clinic seven days after
* treatment to assess if further Hyalase™ is to be administered.
* I accept the clinic terms and conditions. I am satisfied treatment with Hyalase has been explained comprehensively and that the possible risks and side effects associated with the treatment have been fully discussed and understood. I have taken sufficient time to process and consider the information provided and any questions I had have been answered to my satisfaction, before making a decision to proceed with the agreed treatment plan.

Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_   
  
Practitioners Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_